12-014.01B1 Criteria for Care: The client must -

1. Be medically stable or free from complicating major medical conditions;
2. Require minimal/moderate nursing care;
3. Be absent of NG tube, G tube, trach;
4. Require routine physician intervention;
5. Be able to participate in an intensive rehabilitation program (be able to sit up in wheel chair, be able to tolerate full rehabilitation schedule with one rest period per day);
6. Possess a cognitive status such that s/he can communicate his/her basic needs, either verbally or non-verbally. Evidence must show that the client is capable of learning new skills. The client must be at a minimum level V on the Rancho Los Amigos coma scale;
7. Be cooperative and motivated, and absent of addictive habits and anti-social behaviors that would inhibit successful completion of the rehabilitation program;
8. Possess a documented prognosis that indicates that s/he has the potential to successfully complete the rehabilitation program and return to his/her home/community with minimal support;
9. Have documentation supporting that s/he is making continuous progress; and
10. Be unable to be cared for at home, or require multiple services/therapy above those ordinarily provided in a nursing facility.

12-014.01C Other Special Needs Clients: These clients must require complex medical/rehabilitative care in combinations that exceed the requirements of the nursing facility level of care. These clients may also use excessive amounts of supplies, equipment, and/or therapies.

12-014.01C1 Criteria for Care: The client must -

1. Be medically stable;
2. Require multi-disciplinary care;
3. Require care in most or all body systems;
4. Require a complicated medical/treatment regime, requiring intensive care or observation by specially trained professionals (i.e., multiple stage 3 - 4 decubiti on client who is totally dependent on Total Parenteral Nutrition (TPN) or hyperalimentation for all nutrition);

5. Require extensive use of supplies and/or equipment;
6. Have documentation supporting that s/he is making continuous progress; and
7. Be unable to be cared for at home, or require services above those ordinarily provided in a nursing facility.

12-014.02 Facility Qualifications: A Nebraska facility providing services to special needs clients must be licensed by the Nebraska Department of Health as a hospital or skilled nursing facility and be certified in participate in the Nebraska Medical Assistance Program (42 CFR 483, Subpart B). Out-of-state facilities shall meet licensure and certification requirements of that state's survey agency. Out-of-state placement of clients will only be considered when their needed services are not available within the State of Nebraska.

The facility shall demonstrate the capacity/capability to provide highly skilled multi-disciplinary care. The facility shall ensure that its professional nursing staff have received appropriate training and have experience in the area of care pertinent to the individual client's special needs (i.e., ventilator dependent). The facility shall have the ability to provide the necessary professional services as the client requires (i.e., respiratory care available 24 hours per day, seven days a week).

The physical plant shall have all adaptations necessary to meet the client's needs (i.e., emergency electrical backup systems).

12-014.02A Written Policies: The facility shall have written policies specific to the special needs unit and/or individuals regarding -

1. Emergency resuscitation ("code blue" procedures);
2. Fire, natural disaster procedures;
3. Specific nursing procedures typical to care required by the special needs clients;
4. Emergency electrical back-up systems;
5. Equipment failure (i.e., ventilator malfunction);
6. Routine and emergency laboratory/radiology availability; and
7. Emergency transportation.

12-014.02B Documentation Requirements: The facility shall maintain the following documentation for special needs clients:

1. A complete, comprehensive assessment of the individual client's needs before admission. This assessment must be performed by a registered nurse, respiratory care professional, physician, and other health care professionals as indicated by the client's needs (i.e., physical therapist, neurobehavioral management specialist, etc.). The initial assessment must be retained in the client's permanent record;
2. A copy of the admission Form MC-75, "MDS =/-," (Minimum Data Set) and Form DPI-OBRA1, "Identification Screen," must be retained as part of the client's permanent record and be made available to the Department when the client is admitted;
3. A minimum of daily documentation of assessment by an R.N. or respiratory care professional, or other pertinent professionals; and
4. A record of physician's visits.

12-014.02C Financial Records: The facility shall maintain financial records in accordance with 471 NAC 12-011 and 12-012.

12-014.03 Other Requirements: All other support services necessary to meet the care needs of each individual client must be provided under existing contracts or by facility staff as required by Medicare/Medicaid (42 CFR 483, Subpart B) for skilled certification (i.e., respiratory therapy, speech therapy, physical therapy, psychiatric services, occupational therapy, social services, etc.). Specialized rehabilitative services must be provided as needed by clients to improve and maintain functioning as required by 42 CFR 483.45.

12-014.04 Approval Process: NMAP shall pay for a nursing facility service only when prior authorized. Each admission shall be individually prior authorized.

12-014.04A Prior to Admission: A written comprehensive assessment must be sent to the Central Office. The assessment must address how the criteria for care is met. Initial approval/denial will be given. The Pre-Admission Screening Level I Evaluation (see 471 NAC 12-004.04) and Level II Evaluation when applicable (see 471 NAC 12-004.08) must be completed.

12-014.04B In-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date eligibility is determined, facility staff shall -

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C;
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1; and
4. Submit all information to the local office.

Facility staff shall sumbit a copy of the Form MC-75, "MDS =/-," to the Central Office no later than 14 days after admission.

12-014.04C Out-of-State Facility Placement: Within 15 days of the date of admission to the nursing facility or the date eligiblity was determined, facility staff shall -

1. Complete an admission Form MC-9-NF as required by 471 NAC 12-006.01C;
2. Attach a copy of Form DM-5 or physician's history and physical;
3. Attach a copy of Form DPI-OBRA1 (where applicable);
4. Attach a copy of the state-approved MDS; and
5. Submit all information to the Central Office.

The medical review team shall determine final approval for the level of care and return the forms to the local office and the facility. Approval of payment may be time-limited.

12-014.04D Comprehensive Plan of Care: The facility shall submit copies of the comprehenvisve plan of care that documents the client's progress to the Central Office according to the following time frames:

1. Ventilator-dependent clients: as requested;
2. Specialized Long-Term Rehabilitation clients:
   a. In-state: at least annually;
   b. Out-of-state: at least quarterly; and
3. Other Special Needs clients: quarterly.

12-014.05 Payment for Care of Special Needs Clients: Payment for services to all special needs clients shall be prior authorized by Department Medical Services staff in the Central Office.

12-014.05A Nebraska Facilities: To establish a Nebraska facility's payment rate for care of special needs clients -

1. The facility shall submit Form FA-66,"Long Term Care Cost Report," to the Department for each fiscal year ending June 30. Medicare cost reporting forms may be substituted when Form FA-66 is not otherwise required to be submitted. Form FA-66 must be completed in accordance with 471 NAC 12-012, Completion of Form FA-66, "Long Term Care Cost Report," and 471 NAC 12-011 ff., Rates for Nursing Facility Services, as applicable. Medicare cost reports must be completed in accordance with Medicare's Provider Reimbursement Manual (HIM-15). If the facility provides both nursing facility services and special needs services, direct accounting and/or cost allocations necessary to distribute costs between the nursing facility and the special needs unit must be approved by the Department of Social Services Long Term Care Audit Unit.
2. The Department shall compute the allowable cost per day from Form FA-66 or the Medicare cost report, as appliable, which will be the basis from which a prospective rate is negotiated, effective for the following calendar year rate period. Negotiations may include, but are not limited to, discussion of appropriate inflation/deflation expectations for the rate period and significant increases/decreases in the cost of providing services that are not reflected in the applicable cost report. The cost of services generally included in the allowable per diem include, but are not limited to -
   a. Room and board;
   b. Preadmission and admission assessments;
   c. All direct and indirect nursing services;
   d. All nursing supplies, to include trach tube and related trach care supplies, catheters, etc.;
   e. All routine equipment, to include suction machine, IV poles, etc.;
   f. Oxygen and related supplies;
   g. Psycho-social services;
   h. Therapeutic recreational services;
   j. Administrative costs;
   k. Plant operations;
   l. Laundry and linen supplies;
   m. Dietary services, to include tube feeding supplies and pumps;
   n. Housekeeping; and
   o. Medical records.

Services not commonly included in the per diem (unless specifically provided via the facility's contract) include, but are not limited to -

a. Speech therapy;
b. Occupational therapy;
c. Physical therapy;
d. Pharmacy;
e. Audiological services;
f. Laboratory services;
g. X-ray services;
h. Physician services; and
j. Dental services;

These services are reimburse under the Department's established guidelines. Costs of services and items which are covered under Medicare Part B for Medicare-eligible clients must be identified as an unallowable cost.

3. If the facility has no prior cost experience in providing special needs services, the facility shall submit a budget for the provision of the intended service. The Department must concur that the budgeted cost per day meets a reasonable expectation of the cost of providing said service, taking into account the cost per day of similar facilities providing similar services. Budgets will be used until the facility has at least six months of actual cost experience.
4. An incentive factor calculated at eight per cent of allowable costs is added to the allowable costs of proprietary facilities. An incentive factor calculated at four percent of allowable costs is added to the allowable costs of other than propriety facilities;
5. The rate for a facility located in a Metropolitan Statistical Area (MSA) shall not exceed the average acute hospital rate, as of July 1st of each year, for hospitals located in MSA's. The rate for a facility not located in an MSA shall not exceed the average acute hospital rate, as of July 1st of each year, for hospitals not located in MSA's.
6. After a rate is agreed upon, the Department and the provider shall enter into a contract. The contract, written by the Department, must include -
   a. The rate and its applicable dates;
   b. A description of the criteria for care;
   c. A full description of the services to be provided under the established per diem as well as any services that are not provided under the per diem and are billed separately; and

d. Other applicable requirements that are necessary to be included in all Department contracts.

The contract must be signed by both parties before payments may be made for any services provided by the facility.

7. Special services contracts in effect as of January 1, 1994, shall continue in effect until their expiration date.

12-014.05B Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the establishment of the contract rate(s). The payment is not subject to any type of adjustment.

12-014.06 Payment for Bed-Hold: Payment for bed-hold for hospitalization and/or therapeutic leave shall be designated in each individual facility's contract.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

ATMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
E. BENJAMIN NELSON, GOVERNOR

March 24, 1997

Richard P. Brummel
Associate Regional Administrator for Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, MO 64106-2898

Dear Mr. Brummel:

The enclosed Plan Amendment MS-97-2 addresses our nursing facility payment rate methodology for services to Nebraska Medicaid clients. This amendment revises Addendum #3 to the State Plan. Addendum #3 details the computation of the percentage which is used to increase allowable June 30, 1996, costs, to calendar year 1997 interim rates. We request your approval of this State Plan change.

ASSURANCES:

a. REASONABLE AND ADEQUATE RATES: The Department finds that the rates promulgated under this system are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers which provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

b. COSTS OF COMPLYING WITH OBRA 87: The Department finds that the rates promulgated under this system provide for the payment of costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under the title) of complying with the nursing home reform requirements of OBRA 87.

c. COSTS OF COMPLYING WITH Part 483 Subpart B of 42 CFR Ch. IV: The Department finds that the rates promulgated under this system take into account the costs of complying with the requirements of Part 483 Subpart B of 42 CFR Ch. IV.

d. APPROPRIATE REDUCTION: The Department finds that the rates promulgated under this system provide for an appropriate reduction to take into account the lower costs (if any) for nursing care of a facility which is under a waiver of the requirement to provide licensed nurses on a 24 hour basis.

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e. PUBLIC DATA: The Department finds that the data and methodology used in establishing payment rates are available to the public.

f. UPPER LIMITS: This Plan Amendment does not change requirements under Section 12-011.03, which state that "because Title XVIII principles of reimbursement are further restricted by this regulation, the aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities".

Aggregate payments to State operated facilities may not exceed the amount that can reasonably be estimated that would have been paid under Medicare payment principles.

g. PROVIDER APPEALS: This Plan Amendment does not change plan provisions under Section 12-011.13, which provide for a facility appeal process.

h. UNIFORM COST REPORTING: This Plan Amendment does not change plan provisions under Section 12-011.09 which provide for uniform cost reports from all providers.

i. AUDIT REQUIREMENTS: This Plan Amendment does not change plan provisions under Section 12-011.10, which provide for periodic audits.

j. PUBLIC NOTICE: Public notice was published on December 31, 1996.

k. REVALUATION OF ASSETS: This Plan Amendment does not change plan provisions under Section 12-011.06H, which outline the cost basis allowed for facilities purchased on or after December 1, 1984.

l. RATES PAID: Per diem rates are computed in accordance with these methods and standards.

RELATED INFORMATION:

a. The estimated average payment rates are:

	Average Per Diem	
	1/1/96	1/1/97
All Nebraska Facilities	$70.99	$76.70

which may be further broken down as follows:

Located in MSA:		
Waivered	N/A	N/A
Non-Waivered	$85.16	$89.60
Not Located in MSA:		
Waivered	$65.82	$67.42
Non-Waivered	$67.99	$74.13